STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005102	A. BUILDING: _____ B. WING _____	C 10/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORIAL HOSPITAL AND HEALTH CARE CENTER	800 W 9TH ST JASPER, IN 47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This was for investigation of a State complaint. Complaint: #IN00136331 Unsubstantiated: Lack of sufficient evidence. Facility Number: 005102 Survey Date: 10/18/2013 Surveyor: Saundra Nolfi, RN Public Health Nurse Surveyor Memorial Hospital and Health Care Center is in compliance with 410 IAC 15-1.5-6, Nursing Services and 410 IAC 15-1.6-2, Emergency Services, Hospital Licensure Rules. QA: claughlin 10/31/13	S 000		